

## Changing Scope of Public Health Practice Prompts Revisions to List of Notifiable Conditions

Hepatitis C, drowning and near-drowning incidents, and asthma associated with occupational exposures may soon become notifiable conditions in Washington State. These and selected other conditions are being considered for addition to the list of notifiable conditions in the first major review and revision of the state's public health surveillance system in more than a decade.

State law requires health care providers, laboratories, and hospitals to report the occurrence of selected health events to the state or local health departments. Local public health agencies analyze and interpret surveillance data to monitor health events in their jurisdictions, and to plan, implement, and evaluate public health interventions and programs. Surveillance provides especially important data for identifying, investigating, and controlling the spread of infectious diseases and averting epidemics, and for identifying and mitigating the effects of noninfectious, environmental, or occupational conditions.

At a state and national level, public health agencies assess the broader patterns of these conditions, such as historical

trends and geographic clustering, and initiate appropriate actions (e.g., outbreak investigation, policy development, and control activities). The Centers for Disease Control and Prevention (CDC) and the Council of State and Territorial Epidemiologists (CSTE) make recommendations regarding notifiable conditions, but each state has the authority to establish its own list. In Washington, the State Board of Health and the State Department of Health (DOH) are responsible for designating notifiable conditions.

### Information for Action

Several factors have prompted revision of the notifiable conditions list. The scope of public health practice is expanding to include new infectious diseases (e.g., hantavirus pulmonary syndrome, cyclosporiasis) and many noninfectious disease processes, injuries (e.g., burns suffered on the job), and violence (e.g., gunshot wounds). In addition, the epidemiology of specific conditions and available public health interventions are changing. Thus, additions and deletions to the list are necessary to ensure the continued usefulness of the notifiable conditions surveillance system.

As an initial step of the revision process, a diverse working group (including staff from all major DOH units and representatives from local health jurisdictions, the Department of Labor and Industries, and commercial laboratories) used a set of 12 criteria to prioritize conditions for reporting (Table 1). The group developed a draft list of notifiable conditions (Tables 2 and 3, page 2) and also identified conditions to be dropped from the current list (Table 4). The working group is still considering the future status of two groups of state-level reportable

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**TABLE 1: Criteria used to prioritize notifiable conditions in Washington State**

Incidence
Morbidity
Mortality
Communicability and potential for outbreaks
Preventability/treatability
Necessity for immediate public health response
CSTE/CDC recommendations for reporting
WHO Class 1 disease
Socioeconomic impact
Agricultural impact
Emergent condition
Public health action available

89.4

**The reason for collecting, analyzing, and disseminating information on a disease is to control that disease. Collection and analysis should not be allowed to consume resources, if action does not follow.**

William Foege, M.D., M.P.H.,  
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Centers for Disease Control  
and Prevention

## Notifiable Conditions *(from page 1)*

conditions—cancer and birth defects—and animal bites, which are locally reportable.

Guiding principles driving the revision process are the desire to ensure: (1) the need for and usefulness of (i.e., for public health action) data on all proposed notifiable conditions, and (2) fairer and more efficient regulatory systems for reporting and collecting information. The goals are to maximize the benefits of surveillance while minimizing the burdens and costs of conducting surveillance activities.

In contrast to the current list, the revised list includes more noninfectious and occupational conditions. "Core" conditions (Table 2) are being suggested as priority areas for public health practice and the use of resources. "Rare/Unusual" conditions (Table 3) are also of public health interest and importance, but are unlikely to be seen by most providers. This list includes the World Health Organization (WHO) Class 1 diseases that U.S. public health authorities report to WHO.

**TABLE 2: Core diseases and conditions proposed for notification, Washington State, 1998 (DRAFT)**

Acquired immunodeficiency syndrome (AIDS) (including AIDS-defining CD4 lymphocyte counts)	Hepatitis, toxic, occupational*
Asthma, occupational*	Hospitalized burns, occupational*
Blood lead level (children and occupational)	Human immunodeficiency virus (HIV) infection*§
Campylobacteriosis	Measles (rubeola)
<i>Chlamydia trachomatis</i> infection	Mumps
Cryptosporidiosis*	Paralytic shellfish poisoning
Cyclosporiasis*	Pertussis
Diphtheria	Pesticide poisoning
Drowning and near-drowning incidents*	Polio myelitis
<i>Escherichia coli</i> 0157:H7 infection	Rabies, potential human exposure*
Gastroenteritis or other diseases of suspected foodborne or waterborne origin	Rubella (including congenital rubella syndrome)
Giardiasis	Salmonellosis
Gonorrhea	Serious adverse reactions to immunizations
Gunshot wounds	Shigellosis
<i>Haemophilus influenzae</i> type B (invasive)	Syphilis (primary, secondary, congenital, or other)
Hemolytic uremic syndrome (HUS)*	Tetanus
Hepatitis A (acute infection)	Tuberculosis (suspected or diagnosed)
Hepatitis B (acute infection, carriage*, and pregnant women positive for HBsAg*)	Vibriosis
Hepatitis C*	

### *Core Diseases and Conditions Proposed for Sentinel Reporting*

Dermatitis, occupational\*  
Influenza patterns  
Pneumococcal disease (drug-resistant isolates and invasive disease)\*  
Varicella patterns\*

\*Newly added to list

§Inclusion on list does not indicate a decision on format of reporting (e.g., named vs. unnamed).

Over the next 8–10 months, DOH plans to discuss this draft list with local staff of health jurisdictions and boards of health, health care providers and infection control practitioners, managers and staff of laboratories, and administrator and staff of hospitals. DOH will solicit comments regarding feasibility, acceptability, cost, and usefulness of the data, and ideas for implementation. During this time, DOH will also work with these groups to refine the information

*Continued page 4*

**TABLE 3: Rare/unusual conditions proposed for notification, Washington State, 1998 (DRAFT)**

### *World Health Organization Reportable Class 1 Diseases and Conditions (not listed in Table 2)*

Cholera	Relapsing fever (borreliosis)
Malaria	Typhus fever (louse-borne)
Plague	Yellow fever

### *Other Diseases of Public Health Interest*

*Examples:* Anthrax, Botulism (foodborne, infant, and wound), Brucellosis (*Brucella* species), Chancroid, Granuloma inguinale, Hantavirus pulmonary syndrome\*, Viral hemorrhagic fevers\*, Legionellosis, Leptospirosis, Listeriosis, Lyme disease, Lymphogranuloma venereum, *Mycobacterium bovis* infection\*, Psittacosis, Q fever, Trichinosis, Viral encephalitis (arthropod-borne), Yersiniosis

\*Newly added to list

**TABLE 4: Currently reportable diseases and conditions proposed for deletion, Washington State, 1998 (DRAFT)**

Amebiasis  
Food poisoning<sup>1</sup>  
Hepatitis, non-A, non-B  
Herpes simplex, initial genital infection  
Kawasaki syndrome  
Lassa fever  
Leprosy (Hansen's disease)  
Mycobacteriosis (except *M. bovis* and *M. tuberculosis* infections)  
Nongonococcal urethritis (NGU)  
Pelvic inflammatory diseases (acute)  
Pseudomonas folliculitis of suspected waterborne origin  
Rabies (rabies virus)<sup>2</sup>  
Reye syndrome  
Rheumatic fever  
Rocky Mountain spotted fever  
Smallpox  
Tick paralysis  
Toxic shock syndrome

<sup>1</sup>Will be covered under "gastroenteritis and other diseases of suspect foodborne or waterborne origin."

<sup>2</sup>Will be covered under "rabies, potential human exposure" to enable earlier identification and prophylaxis.

# Monthly Surveillance Data by County

March 1998\* – Washington State Department of Health

County	E. coli O157:H7	Salmonella	Shigella	Hepatitis A	Hepatitis B	Non-A, Non-B Hepatitis	Meningococcal Disease	Pertussis	Tuberculosis	Chlamydia	Gonorrhea	AIDS	Pesticides†	Lead\$#
Adams	0	1	0	1	0	0	0	0	0	3	0	0	1	0/0
Asotin	0	1	0	0	0	0	0	0	0	3	0	0	0	0/0
Benton	0	0	0	0	0	0	0	0	0	35	1	1	3	2/29
Chelan	0	0	0	0	0	0	0	0	1	9	3	0	0	3/26
Clallam	0	3	0	0	0	0	0	0	0	11	2	0	0	0/0
Clark	0	4	0	2	1	2	0	1	0	45	6	5	4	0/0
Columbia	0	0	0	0	0	0	0	0	0	0	0	0	0	0/0
Cowlitz	0	0	0	1	0	0	0	0	0	15	0	3	0	2/17
Douglas	0	0	0	0	0	0	0	0	0	5	0	0	0	0/0
Ferry	0	0	0	0	0	0	0	0	0	2	0	0	0	0/0
Franklin	0	1	0	0	1	0	0	0	1	8	0	0	1	1/#
Garfield	0	1	0	0	0	0	0	0	0	1	0	0	0	0/0
Grant	0	0	0	2	0	0	0	0	0	22	0	0	0	0/8
Grays Harbor	0	0	0	3	0	0	0	0	0	7	0	0	0	0/0
Island	0	0	0	1	0	0	0	0	0	9	0	1	0	0/6
Jefferson	0	0	0	0	0	0	0	0	0	1	0	0	0	1/#
King	0	18	3	36	9	0	2	13	9	268	95	37	6	1/29
Kitsap	0	1	1	3	0	0	2	1	0	56	4	1	0	0/36
Kittitas	0	0	0	1	0	0	0	0	0	4	0	0	0	0/0
Klickitat	0	0	0	0	0	0	0	0	0	0	0	0	0	0/0
Lewis	0	0	0	0	0	0	0	0	0	5	2	0	1	0/0
Lincoln	0	0	0	0	0	0	0	0	0	0	0	0	1	0/0
Mason	0	1	0	0	0	0	0	0	1	6	0	0	0	0/0
Okanogan	0	0	0	0	0	0	0	0	0	8	0	1	0	0/#
Pacific	0	0	0	0	0	1	0	0	0	1	0	0	0	0/#
Pend Oreille	0	0	0	0	0	0	0	0	0	0	0	0	0	0/0
Pierce	0	1	1	6	2	0	2	8	4	130	22	5	2	1/140
San Juan	0	0	0	0	0	0	0	0	0	0	0	1	0	0/0
Skagit	0	0	0	1	0	0	0	0	1	15	1	0	1	0/#
Skamania	0	0	0	0	0	0	0	0	0	0	0	0	0	0/0
Snohomish	0	5	0	4	1	0	0	7	0	75	7	5	0	0/8
Spokane	7	7	0	27	0	0	0	0	0	55	10	0	0	0/21
Stevens	0	0	0	0	0	0	0	0	0	5	0	0	0	0/#
Thurston	0	3	0	5	0	0	0	0	0	16	2	0	0	0/9
Wahkiakum	0	0	0	0	0	0	0	0	0	0	0	0	0	0/0
Walla Walla	0	1	0	0	0	0	0	0	0	8	0	0	1	0/5
Whatcom	1	4	0	1	0	0	0	1	0	14	0	0	0	0/#
Whitman	0	0	0	3	0	0	0	0	0	9	0	0	0	0/0
Yakima	0	2	0	2	0	0	1	4	0	57	0	0	2	0/16
Unknown														0/0

Current Month	8	54	5	100	14	3	7	35	17	908	155	60	23	11/362
March 1997	6	28	15	58	6	3	9	40	26	730	145	83	12	10/386
1998 to date	10	61	10	150	19	5	23	64	46	2517	438	127	38	29/906
1997 to date	8	92	30	138	14	6	26	75	68	2285	538	195	29	34/1038

\* Data are provisional based on reports received as of March 31, unless otherwise noted.

† Unconfirmed reports of illness associated with pesticide exposure.

\$# Number of elevated tests (data include unconfirmed reports) / total tests performed (not number of children tested); number of tests per county indicates county of health care provider, not county of residence for children tested; # means fewer than 5 tests performed, number omitted for confidentiality reasons.



## WWW Access Tips

The website address for the AIDS Prevention Unit of the Seattle-King County Department of Public Health is: <http://www.metrokc.gov/health/apu>

### Questions? Comments?

If you have a question about epidemiologic or public health issues, contact the editors at the address on the mailing panel or by email at [function@u.washington.edu](mailto:function@u.washington.edu)

## Washington Responds to HIV Outbreak in Vancouver, B.C.

A recent outbreak of human immunodeficiency virus (HIV) infection among injecting drug users (IDUs) in Vancouver, B.C., was the focus of a March 2 statewide conference for health professionals sponsored by the Washington State Department of Health (DOH). Vancouver's proximity and the likelihood of travel by IDUs and their sex partners along the I-5 corridor has prompted widespread concern that HIV could spread into similar high-risk populations in Washington State (see *epiTRENDS*, November 1997).

Current data from anonymous seroprevalence surveys and results from a longitudinal cohort study of more than 3,000 IDUs in Seattle-King County from June 1994 through 1997 show that HIV seroprevalence among IDUs is stable ( $\leq 2\%$ ) and that the annual incidence of new infections is low (0.2%). By contrast, the incidence of infections among IDUs in Vancouver reached 18.6% in mid-1997 but has since declined to 3–4%.

Several factors may contribute to the differing incidence rates in Seattle and Vancouver. In Seattle, IDUs tend to use heroin rather than cocaine, and those enrolled in the cohort study have shown a declining frequency of cocaine use in recent years. In addition, Seattle has stricter law enforcement policies, a relative absence of "shooting galleries" and single-room occupancy hotels, a local IDU culture with minimal drug-sharing behaviors, and a more geographically dispersed drug-using community.

Conference participants identified a need for local data with which to monitor the potential spread of HIV infection in all areas of the state. As a result, DOH is formulating questions that will provide more insight into drug-using behavior and that can be added to forms used to track the characteristics of clients seeking anonymous HIV testing at public sites. In addition, DOH has prepared county-specific summaries of population-based indicators of drug-using and needle-sharing behaviors, including rates of hepatitis B, hepatitis C, arrests for possession of opium and cocaine, and hospitalizations for illicit drug use. Local health districts are encouraged to use these indices as a baseline against which to track future trends.

DOH is planning discussion sessions at the 1998 Washington State Joint Conference on Public Health in Yakima (October 5–7) that will focus on monitoring of HIV infection and drug-using behaviors and on outreach activities for high-risk, hard-to-reach populations. ♦

## Surveillance *(from page 2)*

flow to make the system as user-friendly as possible and to improve the completeness and accuracy of surveillance information.

To obtain more information about the notifiable conditions revision or to provide comments, please contact Greg Smith at 360-236-3704 or by electronic mail at [gts0303@hub.doh.wa.gov](mailto:gts0303@hub.doh.wa.gov).

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